QUESTIONS FROM 01/29/10 DMC PROVIDER MEETING

Contracts

1. **Is a case conference billable, since it is a face-to-face contact with the conference team?**

   No, Title 22 does not allow for the billing of case conferences.

2. **Does the medical provider have to be present at the case conference?**

   The medical director's presence at case conferences is not a requirement. However, the medical director is responsible for all agency clients and should be engaged in the provision of service.

3. **Do you have to have a separate sign in sheet/book for individual counseling?**

   You do not need a sign-in sheet for individual sessions but you must record a progress note for every session. Progress notes must list the time, date, justification for the session, and results of the session. They must be signed by the counselor who facilitated the session.

4. **Is it really necessary to have a 90-day review when you have to address the treatment plan in 90 days anyway? Wouldn't it make more sense to do it 60 days? This would support client's progress and counselor's assessment. Please advise.**

   A case review shall be conducted within 30 days of admission and every 90 days thereafter. This is a minimal time requirement; however, it can be conducted more often.

   The purpose of a case review is to ensure that the treatment plan is relevant to the stated problems, the services being delivered are appropriate and that documentation is maintained in accordance with all relevant regulations. Therefore, when a supervisor/reviewer examines the client chart, it behooves them to review the intake information, progress notes and treatment plan. In this way, the supervisor/reviewer signs the treatment plan indicating support of the counselor's assessment and awareness of client's progress. You may refer to your State Alcohol and Other Drug Treatment Certification Standards section 17020b for more information on case reviews.

5. **Could County provide a specific example of forms to be used? For example, assessment, medical waiver, etc. Reason being auditors and supervisors change and/or State forms used do not meet standards…Can we all have a written example to use as a foundation...**

   The Resources page of the training handout lists the reference materials and websites where you can find the forms that meet all State requirements. County Contract Program Auditors may also provide additional examples of forms upon request. However, it is an agency's responsibility to read all relevant regulations and develop forms that collect the required information/documentation.

6. **Page 25 of large packet - Are you referring to Medi-Cal Medical Director or County Monitor?**

   Page 25 of the presentation hand-out references the Annual Justification. This is a contract requirement that states: "Based upon the continuing treatment needs of the client, the duration of any individual's treatment hereunder shall not exceed twelve months without the prior written approval of the **Director**".

   The above refers to the Director of Substance Abuse Prevention and Control. As a matter of protocol, the annual justification is completed by the agency with all required information necessary to verify the need for an extension beyond one year of treatment services and submitted to the agency's Contract Program Auditor. The Contract Program Auditor will review the extension request and provide a response. If that response is an approval for the extension, then a copy of the annual justification with the signature of the Contract Program Auditor must be placed in the client's chart.

7. **Capacity to Benefit - are there specific Dx's that require mental health provider documentation or approval?**

   The requirement in the County's Exhibit reads, "...a severe mental health diagnosis (e.g. bipolar, schizophrenia, etc.) and are referred from an adult residential facility..." Beyond that there is no list of specific diagnoses.

8. **DSM Code - Do the clients have to have a dependence code or can the code be for abuse?**

   A DSM diagnosis of **"substance abuse"** qualifies for all aspects of the program. Remember, the code must correspond to the information obtained in the intake process or a subsequent re-assessment.

9. **Why didn't Gil's budget pages have "Drug Medi-Cal" boxes checked off on the top left of each page?**

   The budget presentation was meant to make the budgeting process easier for Contractors. It was not meant to be all inclusive. When completing budgets for DMC contracts, the agency should check off the DMC box at the top left of the page.

10. **On the first page of the budget, the shaded areas are hard to read.**

    That will not be the case when the spreadsheet is displayed on your computer screen. Many areas are color coded to indicate where you can enter data and where you cannot enter data. All formulas are "protected" or locked to maintain the integrity of the calculations that the file will perform for you.

11. **How can we obtain copies of other providers' budgets?**

    SAPC does not provide copies of budgets from other agencies.

12. **Does the medical doctor have to be the one diagnosing the DSM code? Can you have a licensed therapist diagnosing, and have the doctor confirm it by signing the treatment plan?**

    The therapist and/or certified/registered counselor may recommend a diagnosis based upon the substance abuse history obtained during the assessment, but the burden of making the diagnosis rests with the physician who is responsible for directing all beneficiary treatment and medical services.

13. **Crisis Intervention with outpatient many crises and troubleshooting occur via the phone especially with adolescents. Are we not allowed to bill for an actual crisis intervention on the phone?**

    No, all DMC treatment services, including crisis intervention, must be face-to-face.

Finance

1. **Why does it take the County too long to change the correct rates of billings in the system?**

   The delay is in the time it takes before the County receives official notice from the State on new or revised DMC billing rates. It is the State that determines these rates, and the County is obligated to apply these rates upon receipt of official notice. The County of Los Angeles usually receives these notifications from the State at least one month after the new rate's effectivity. Upon receipt of the notification, the County will begin processing amendments to the contracts to revise the billing rates. Once the necessary amendments are completed, the new rates will be applied to billings, beginning with those being processed for payment.

2. **Why are agencies required to pay back money when the rates changed to a lower rate? The revised rates didn't "hit" the system until several months after the rate decrease. However, the system continued allowing payments at the old rate. The County is now asking retroactive reimbursements.**

   Payments to claims are processed following the terms of the agency's contract with the County at the time the claims were submitted. However, when the State declares rate changes and the County receives appropriate notice, the County is obligated to amend affected contracts and apply the new rates to claims. Sometimes delays occur and the State notice does not get to the County until months after rate change effectivity. When this happens and claims affected by this rate change have already been paid using the old (higher) rates, then the concerned agency is required to pay back to the County the computed difference for the affected period(s).

# # # #